CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/11/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155506			(X2) MULTIPLE CONSTRUCTION  A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/15/2011	
	PROVIDER OR SUPPLIER		STREET 17475	ADDRESS, CITY, STATE, ZIP CODE DUGDALE DR H BEND, IN46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
F0000	complaint IN000  Complaint IN000 Federal/State defallegations are cife-309, F 312, and Survey dates: M  Facility number: Provider number Aim number:  Surveyors: Antoinette Krako Becky Luft, RN Vicki Manuwal, Census bed type: SNF/NF: 113 Total: 113  Census payor type Medicare: 43 Medicaid: 56 Other: 14 Total: 113  Sample: 5 Supplemental Sample: 5 Supplemental Sample: 5	087550 substantiated, ficiencies related to the ted at F-224, F-241, d F-469.  Farch 14 and 15, 2011  001201  155506 100380860  Dwski, RN, TC  RN	F0000	Submission and implementation of this plan of correction in no constitutes an admission or agreement of the truth of fact alledged in this statement of deficiencies and plan of correction. In fact, this plan of correction is submitted and implemented soley to comply State and Federal law.	way ts	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SQIC11

Facility ID:

001201

If continuation sheet

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155506			(X2) MULTIPLE CO  A. BUILDING  B. WING		- COM	(X3) DATE SURVEY COMPLETED 03/15/2011	
	PROVIDER OR SUPPLIE		17475 [	ADDRESS, CITY, STATE, ZIP CO DUGDALE DR I BEND, IN46635	DE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	findings in acco	rdance with 410 IAC 16.2.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED	
		155506	B. WIN			03/15/2011	
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SOLI EIER			1	DUGDALE DR		
SANCTU	ARY AT HOLY CRC	OSSINDIANA		SOUTH	H BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	E02	TAG	F2241. What corrective action	will 02/20	
F0224		rvation, interview,	F02	24	be accomplished for those	will 03/29	/2011
SS=E		riew, the facility			residents found to be affected	, ,	
	failed to ensur	e residents needs			the deficient practice: Head to assessment were completed or	<b>I</b>	
	were met by an	nswering call lights in			all resident to ensure skin	"	
	a timely mann	er (Residents: #E and			integrity. Medline representati	ves	
	#F) and provid	ling continence care			and nursing administration reviewed incontinence needs	or	
	to incontinent	residents who were			incontinent residents and		
	made to lie soi	iled in their bed			implemented new system and		
	(Residents #E.	, #G, #H) which			incontinence supplies to mana incontinent residents.2. How	- 1	
	,	development of an			other residents having the	v	
		one resident (Resident			potential to be affected by the		
	# E). This def	`			same deficient practice will be identified and what corrective		
	· ·	•			action will be taken for any oth	er	
		residents (Residents:			affected resident:Rersidents		
		the sample of 5 and 2			requiring assistance with incontinence care have the		
		(Residents #G and			potential to be affected.Medlin	e	
		plemental sample of			representatives and nursing		
	2 reviewed for	incontinence.			administration reviewed incontinence needs for		
					incontinent residents and		
	Findings inclu	de:			implemented new system and		
					incontinence supplies to mana incontinent residents. Head to	~ I	
	1. Resident # I	E's clinical record was			assessments were completed		
	reviewed on 3	/15/11 at 3:00 P.M.			incontinent residents to assure		
		diagnoses of, but not			skin integrity.3. What measure will be put into place or what	es	
		g cancer, DVT (deep			systemic changes will be made	e to	
	· ·	• • • •			ensure that the deficient practi	ce	
		is) and pulmonary			does not recur. All staff was inserviced on the expectation	and	
	emboli.				responsibilities of answering c	<b>I</b>	
					lights.Abuse and neglect traini	ng	
	During an interview with alert and				was provided to all staff.Nurse	<b>I</b>	
					Administration has been assig	ned	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155506	A. BUI	LDING		COMPLETED 03/15/2011
		155500	B. WIN		A DDDDGG GUTV GT TO COD	03/13/2011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE  DUGDALE DR	
SANCTU	ARY AT HOLY CRC	SSINDIANA		1	H BEND, IN46635	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
1710		ent # E on 3/15/11 at		mo	off hour shifts to assure call lig	
		indicated she often			and incontinence care of residents is timely.4. How the	
		o or more hours			corrective action will be monite	
		ne comes to answer			to ensure the deficient practice	•
		'If a person died in			will not recur. Nursing administration will audit all uni	ts
	_	one would know until			for compliance with answering	l l
	_				call lights and incontinence ca	
	_	t if my roommate had How would I get her			is being provided timely,one ti per shift on all 3 shifts and tot	
					of four times per week report	
	•	ther indicated she			findings to the Director of Nurs at morning clinical meeting.So	
		n a laxative because			worker will randomly question	
		g difficulty with			staff per day 5 days a week to	
	_	nd had soiled herself.			ensure staffs inowledge of abu and neglect responsibilities an	
	"I had Depend	's (an incontinence			report findings to the	
	brief) on. I try	to keep a Depend's			administrator daily at clinical	
	on because you	u never know when			meetings.Social Worker will interview 5% of residents and	/or
	they (staff) are	going to show up.			families weekly to ensure qual	
	(CNA # 2) can	ne in and told me she			of care is being provided to residents.Corporate Regional	
	would clean m	e up when I finished.			Nurse will round community da	aily
	I didn't know i	f I was finished or			3 days per week for 6 months	to
	not. I know it	was loaded. She			ensure call lights are answere and incontinence care is provi	
	made me wait	a long time before			timely.Director of Nursing and	
		to clean me up. The			Administrator will review, follow	
		utt was sore and			up and report audit findings to (MDQI) monthly until 100%	
		(age) years old and			compliance is obtained times	
	_	my pants two times			months.5. Completion date Ma 29, 2011	arcn
	_	ecause no one came."			20, 2011	
		ndicated she had				
		Social Worker #8				
		Social Wolker 110				
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	SQIC11	Facility	ID: 001201 If continuation s	heet Page 4 of 48

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155506			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED 03/15/2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE DUGDALE DR	1	
	SUMMARY S  (EACH DEFICIENCE REGULATORY OR  about her conce  A Social Servi Data Set) Asset 3/15/11, indicate is alert and ori and situation. It out of 15 indic cognitive func 3/07/11"  Nurse's Notes, P.M., indicated Skin check reve excoriation bil buttocks L (left measures 0.5 x pink tissue & I buttocks measures (centimeters) process depth"	pssINDIANA TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION) THE PERCENTIFY IN THE PE	B. WIN	STREET A			(X5) COMPLETION DATE
	mentioned area 3/04/11.	as upon admission on					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			URVEY ETED	
		155506	A. BUII B. WIN			03/15/20	
NAME OF D	PROVIDER OR SUPPLIER		D. WIIS	_	ADDRESS, CITY, STATE, ZIP CODE	!	
				1	DUGDALE DR		
	ARY AT HOLY CRO				I BEND, IN46635		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Review of the	Grievance Log					
	indicated Resi	dent #E complained					
	to administrati	on on two separate					
	occasions rega	rding call light					
	response times	and staffing					
	concerns.						
	Social Worker	#8 indicated in an					
	interview on 3	/15/11 at 5:45 P.M.					
	that it was not	reported to her that a					
	CNA left the re	esident soiled. I met					
	with the reside	ent, but her complaint					
	was that she co	ouldn't get herself up					
	to the bathroon	n because of					
	weakness and	safety issues. I					
	immediately w	ent to the therapy					
	department and	d they began working					
	with her. She	never					
	mentioned the	other issue.					
	_	ation of Resident #					
		5/11 at 5:05 P.M.,					
	while accompa	•					
	_	Resident E's open					
	areas appeared						
		ndicated at the time					
	of the observat	tion that the areas no					
	longer caused	her pain.					

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l	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155506		(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 03/15/2011	
	PROVIDER OR SUPPLIER		17475 [	ADDRESS, CITY, STATE, ZIP COE DUGDALE DR I BEND, IN46635	DE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
	on 3/14/11 at a accompanied be accompanied by accompanied by a sobserve bed. LPN # 5 is as inconting two hour check. Upon further of two hour check. We see that a small we a larger, dry, go dried urine.  Review of Reserved on 3/15 indicated diagrammed to: All depression, and tract infection.  Resident #G's MDS (Minimum assessment, daindicated his conserved impair of two hour check.)	most recent quarterly um Data Set) ated 2/11/11,					
				!			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  155506			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  D. WING			(X3) DATE SURVEY COMPLETED 03/15/2011	
		10000	B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE	00/10/2	
NAME OF F	PROVIDER OR SUPPLIER				DUGDALE DR		
	ARY AT HOLY CRO			SOUTH	BEND, IN46635		
(X4) ID PREFIX				ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	indicated he no	eeded extensive					
	assistance of two persons with						
		=					
	ix (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  indicated he needed extensive						
	to determin	ne if she had been					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155506		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/15/2011		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE  17475 DUGDALE DR SOUTH BEND, IN46635				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
	was observed sheet and on to groin area. The odor present. The repositioned the dry, golden browserved beneated the area outer ring of the brown than the indicated the area of the reviewed on 3 and indicated limited to: defend (shortness of the and failure to and failure to the care-toileting, dressing, ADI living)"	eath Resident #H. The he area was a darker e center. LPN #7 hrea was dry.  Elinical record was /15/11 at 6:10 P.M. diagnoses of, but not hydration, dyspnea breath) on exertion, thrive.  e, dated 3/10/11 at hedicated, "Able to					

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	STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  155506		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE S COMPL	ETED
		155506	B. WIN	NG		03/15/2	011
NAME OF F	PROVIDER OR SUPPLIER		_	1	ADDRESS, CITY, STATE, ZIP CODE		_
SANCTU	IARY AT HOLY CRO			1	DUGDALE DR I BEND, IN46635		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
	the time of the	observation, she					
	indicated the e	evening shift makes					
	sure all the res	idents are clean and					
	repositioned p	rior to leaving their					
	shift at 11:15 I	P.M. and the night					
	shift begins re	sident checks					
	immediately a	fter receiving report.					
		al tour of the facility					
		11:50 P.M., Resident					
	#F's family me	ember reported the					
	poor response	of facility staff to					
	answering call	lights and providing					
	necessary care	. She indicated she					
	has found her	mother with dried					
	feces on her ba	ackside and between					
		quently find her with					
	an odor and he	er call light disabled."					
	She indicated	she saw the call light					
		nall from her mother					
	and witnessed	a CNA enter the					
	room and imm	nediately exit. The					
	call light had b	been turned off. After					
	some time, the	e resident began					
	calling out and	l Resident #F's					
	_	into the room to					
	check on the re	esident. She informed					
	the resident to	put her call light					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING		COMPL	
		155506	B. WIN	G		03/15/2	011
NAME OF F	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE		
CANCTL		ACC INIDIANIA		1	DUGDALE DR		
	IARY AT HOLY CRO				I BEND, IN46635		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	back on and w						
resident that she had tried, but it							
		ng. "I know someone					
		because I've found					
		all light like that. We					
	l *	wo hours with the call					
	light on during	g the evening shift.					
	There's nothin	g you can do about it					
	because there	isn't anyone around.					
	The nurse's wo	on't answer the lights,					
	they pass the r	nedications and sit at					
		villing to organize a					
		the facility can afford					
		art-time help. I hear					
	_	out 'Help me. Help					
	me."	out freip me. freip					
	inc.						
	   Resident #F's (	clinical record was					
		/15/11 at 4:35 P.M.					
		diagnoses of, but not					
		tory of CVA (stroke),					
		•					
	i diaucies, and \	vascular dementia.					
	Review of Res	sident #F's MDS					
		ta Set) Assessment,					
	`	· · · · · · · · · · · · · · · · · · ·					
	dated 1/21/11,						
	needed extensive physical assistance of two staff for toilet use						
	assistance of the	wo stall for tollet use					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPL	
		155506	B. WIN			03/15/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SANCTU	IARY AT HOLY CRO	)\$\$_INDIANA		1	DUGDALE DR I BEND, IN46635		
					DEND,   \ <del>+</del> 0000		(2/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	(how resident	uses the toilet room,					
commode, bedpan, or urinal;							
	transfers on/of	f toilet; cleanses self					
	after eliminati	on). It further					
	indicated Resi	dent #F was					
	frequently inco	ontinent of urine and					
	occasionally in	ncontinent of bowel.					
	A Care Plan, u	pdated 1/20/11,					
	indicated, "Pro	oblem(s): I require					
	extensive assis	st with ADL's					
	(activities of d	aily living) due to					
	· '	reased mobility and					
	· · · · · · · · · · · · · · · · · · ·	Approach(s):					
		ne to use call light for					
	_	mind me where it is					
	· ·	eady to leave the					
		assist with proper					
	_	each incontinint (sic)					
	episode"						
		ce Progress Note,					
	dated 1/24/11	at 3:42 P.M.,					
	indicated, "F	Res (resident) is alert					
	and oriented to	person with					
	forgetfulness	Severe cognitive					
	impairment"						
	_						

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		155506	B. WIN			03/15/2011	
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	•	
SANCTU	ARY AT HOLY CRO	099_INIDIANIA		1	DUGDALE DR I BEND, IN46635		
				<u>l</u>	I DEND, IN40033		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMI	(X5) PLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	ATE
	During an inte	rview with a second	İ				Î
	family member on 3/15/11 at 4:20						
	P.M., she indic	cated it takes a long					
	time for staff t	o answer call lights.					
	She further inc	licated she found her					
	mother in BM	(bowel movement)					
	three weeks ag	go.					
	A facility police	cy titled					
	"Incontinence Management,						
	Urinary," date	d 1/08/11, indicated,					
	-	functional (total)					
	_	frequently assess the					
		al and functional					
	statusrespon						
	-	an the perineal area					
		ntrol foul odors as					
	well"						
	A facility police	cy titled, Incontinence					
	J 1	Fecal," dated 1/08/11,					
		n elderly patients,					
	· ·	ence commonly					
		ss or impairment of					
	*	controlmaintain					
	_	enic care to increase					
		omfort and prevent					
	_	n and infection.					
	Skill Ulcakuow	ii and infection.					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	PROVIDER OR SUPPLIER		STREET A 17475 [	ADDRESS, CITY, STATE, ZIP COD DUGDALE DR I BEND, IN46635	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
IAU	Clean the period with a skin cle skin protectan	neal area frequently eaner, and apply a t cream after every episode. Control foul"	IAG			DATE

NAME OF PROVIDER OR SUPPLIER SANCTUARY AT HOLY CROSSINDIANA  A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 17475 DUGDALE DR SOUTH BEND, IN46635	
NAME OF PROVIDER OR SUPPLIER  17475 DUGDALE DR	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMPL CROSS-REFERENCED TO THE APPROPRIATE	(X5) MPLETION DATE
	/29/2011
and record review, the facility failed to respect the dignity of 4 residents as evidenced by observation of 2 soiled residents (Residents: #G, #H), an interview with 1 alert and oriented resident (Resident #E) and interviews with family members of an incontinent resident (Resident #F) left soiled, and 1 resident (Resident #C) with a folded bed pad between her legs. This deficient practice affected 3 of 5 residents in the sample of 5 and 2 of 2 residents in the sample reviewed for continence care.  Findings include:  1. During initial tour of the facility on 3/14/11 at 11:10 P.M., while accompanied by LPN # 5, Resident #G was observed lying asleep in his bed. LPN # 5 identified Resident #G assure skil integrity. Medline representatives and incontinence needs for incontinent residents and implemented new system and incontinence supplies to manage incontinent residents having the potential to be affected by the deficient practice: Head to te skin assessments were completed on all residents and incontinence needs for incontinent residents. All the potential is to be same deficient practice will be same deficient practice.  Findings include:  1. During initial tour of the facility on 3/14/11 at 11:10 P.M., while accompanied by LPN	

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155506	B. WIN			03/15/2011	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				DUGDALE DR		
SANCTU	ARY AT HOLY CRO	SSINDIANA		1	H BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		DATE	
	#G was found	to be soiled from			that the deficient practice does not recur. All staff was inservice	l l	
	urine. His quilted incontinence pad				on the expectation and		
	had a small we	et area surrounded by			responsibilities of answering c	all	
		· · · · · · · · · · · · · · · · · · ·			lights.Dignity training was		
		golden brown stain of			provided to all staff.4. How the		
	dried urine.				corrective action will be monito		
					to ensure the deficient practice will not recur. Nursing	=	
	Review of Res	sident #G's clinical			administration will audit all uni	ts	
					for compliance with answering		
	record on 3/15/11 at 5:35 P.M., indicated diagnoses of, but not				call lights and incontinence ca		
					is provided timely,one time pe		
	limited to: Alzheimer's dementia,				shift on all 3 shifts and a total	of	
	depression, and history of urinary				four times per week report findings to the Director of Nurs	sina	
	tract infection.	•			at morning clinical meeting.So		
	l'act infection.	•			worker will randomly question		
					staff per day 5 days a week to		
	Resident #G's	most recent quarterly			ensure staffs Inowledge of abu	l l	
	MDS (Minimu	ım Data Set)			and neglect responsibilities an	id	
	assessment, da	nted 2/11/11			report findings to the administrator daily at clinical		
	· ·	· · · · · · · · · · · · · · · · · · ·			meetings.Social Worker will		
	indicated his c				/or		
	severely impai	ired and he never or			families weekly to ensure qual	lity	
	rarely made de	ecisions. It further			of care is being provided to		
	indicated he no	eeded extensive			residents.Corporate Regional Nurse will round community		
		wo persons with			daily 3 days per week for 6		
		•			months to ensure call lights ar	e	
	physical assist	for toileting.			answered and incontinence ca	l l	
					is provided timely.Director of		
	A Care Plan, d	lated 1/11/11,			Nursing and Administrator will	, dit	
	<b></b>	oblem: I have altered			review, follow up and report at findings to (MDQI) monthly	uuit	
	ŕ				until 100% compliance is		
	urinary elimination pattern related				obtained times 3 months.5.		
	to dx. (diagnos	· ·			Completion date March 29, 20	)11	
	dementiaAp	proach:Keep me					
		-					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155506			A. BUI	LDING	NSTRUCTION	(X3) DATE S COMPL 03/15/20	ETED
NAME OF A			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER			1	DUGDALE DR		
	ARY AT HOLY CRO			<u>l</u>	BEND, IN46635		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	VIE.	DATE
	dry and clean a						
	incontinence e	pisode"					
		1 . 1 2 /4 7 /4 4					
		e, dated 3/15/11 at					
	· ·	dicated, "Resident					
	continues on a						
		I (urinary tract					
	infection)res	bowel & bladder"					
	incontinent of	bower & brauder					
	2 During initis	al tour of the facility					
		11:45 P.M., while					
		by LPN # 7, Resident					
	•	yed lying in her bed.					
		control was observed					
	-	oor at the right side					
	• •	PN # 7 pulled back					
		nd checked Resident					
	#H to determing	ne if she had been					
	incontinent. A	white terry towel					
	was observed	lying beneath the top					
	sheet and on to	op of Resident H's					
	groin area. The	ere was a strong urine					
	odor present. V						
	_	ne resident, a large,					
	dry, golden bro						
		ath Resident #H. The					
	outer ring of th	ne area was a darker					

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	NSTRUCTION	(X3) DATE S COMPL	
		155506	B. WIN			03/15/2	011
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	1	ADDRESS, CITY, STATE, ZIP CODE		
SANCTU	JARY AT HOLY CRO	NSSINDIANA			DUGDALE DR BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	DEND, IN 10000		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	WE.	DATE
	brown than the	e center. LPN #7					
	indicated the a	rea was dry.					
	Resident H's clinical record was						
	reviewed on 3	/15/11 at 6:10 P.M.					
	and indicated	diagnoses of, but not					
	limited to: deh	ydration, dyspnea					
	(shortness of b	oreath) on exertion,					
	and failure to t	thrive.					
	A Nurse's Note	e, dated 3/10/11 at					
	10:30 P.M., in	dicated, "Able to					
	use call light e	et (and) voice					
	needsExtens	ive assist for personal					
	care-toileting,	personal hygiene,					
	dressing, ADL	's (activities of daily					
	living)"						
	During intervi	ew with LPN #7 at					
	the time of the	observation, she					
	indicated the e	evening shift makes					
	sure all the res	idents are clean and					
	repositioned p	rior to leaving their					
	shift at 11:15 I	P.M. and the night					
	shift begins re	sident checks					
	immediately a	fter receiving report.					
	3. Resident #	E's clinical record					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155506		A. BUI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/15/2011	
	PROVIDER OR SUPPLIEF	<b> </b>	B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
	JARY AT HOLY CRO	DSSINDIANA		SOUTH	BEND, IN46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	was reviewed	on 3/15/11 at 3:00					
	P.M. and indic	cated diagnoses of,					
	but not limited	d to: lung cancer,					
	DVT (deep ve	ein thrombosis) and					
	pulmonary em	nboli.					
	During an inte	erview with alert and					
	oriented Resid	lent # E on 3/15/11 at					
	2:40 P.M., she	e indicated she often					
	has to wait tw	o or more hours					
	before someone comes to answer						
	her call light. "If a person died in						
	this place, no	one would know until					
	morning. Wha	nt if my roommate had					
	a heart attack?	How would I get her					
	help?" She fur	ther indicated she					
	had been give	n a laxative because					
	she was havin	g difficulty with					
	constipation a	nd had soiled herself.					
	"I had Depend	l's (an incontinence					
	brief) on. I try	to keep a Depend's					
	on because yo	ou never know when					
	they (staff) are	e going to show up.					
	(CNA # 2) car	me in and told me she					
	would clean n	ne up when I finished.					
		if I was finished or					
	not. I know it	was loaded. She					
	made me wait	a long time before					
	l						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155506			A. BUI	LDING	NSTRUCTION	(X3) DATE S COMPL 03/15/2	ETED
		100000	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/10/2	
NAME OF I	PROVIDER OR SUPPLIER			1	DUGDALE DR		
	IARY AT HOLY CRO			1	I BEND, IN46635		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	she came back	to clean me up. The					
	next day my butt was sore and						
	bleeding. I am	(age) years old and					
	_	my pants two times					
		ecause no one came."					
		ndicated she had					
	_	Social Worker #8					
	about her conc	eerns.					
		MDG (M; ;					
	A Social Service MDS (Minimum						
	·	essment Note, dated					
		nted, "Resident (#E)					
		ented to time, place,					
		Resident scored 15					
	out of 15 indic						
	cognitive func	tioning on					
	3/07/11"						
	1 During initi	al tour of the facility					
		11:50 P.M., Resident					
		ember reported the					
	1	of facility staff to					
		lights and providing					
		She indicated she					
		mother with dried					
		ackside and between					
		quently find her with					
	_	er call light disabled."					
	an odor and no	a can right disuoled.					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		155506	B. WING		03/15/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE DUGDALE DR	
SANCTU	ARY AT HOLY CRO	OSSINDIANA	I	H BEND, IN46635	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL	
TAG	*	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE DATE
		she saw the call light			
		nall from her mother			
		a CNA enter the			
		nediately exit. The			
	_	been turned off. After			
	· · · · · · · · · · · · · · · · · · ·	resident began			
	_	l Resident #F's			
	_	into the room to			
		esident. She informed			
		put her call light			
	back on and w				
	resident that sh	ne had tried, but it			
	stopped worki	ng. "I know someone			
	did something	because I've found			
	my mother's ca	all light like that. We			
	have waited tw	vo hours with the call			
	light on during	g the evening shift.			
	There's nothin	g you can do about it			
	because there	isn't anyone around.			
	The nurse's wo	on't answer the lights,			
	they pass the n	nedications and sit at			
	the desk. I'm v	villing to organize a			
	fund raiser so	the facility can afford			
	to hire some pa	art-time help. I hear			
	people calling	out 'Help me. Help			
	me."	_			
	Pasidant #Ela	clinical record was			
	Resident #F'S (	cinnical record was			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155506				ULTIPLE CO LDING	NSTRUCTION	COMPL	ETED
		155506	B. WIN			03/15/2	U11
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE  DUGDALE DR		
SANCTU	ARY AT HOLY CRC	SSINDIANA		1	I BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE
_		/15/11 at 4:35 P.M.					
		diagnoses of, but not					
		tory of CVA (stroke),					
		vascular dementia.					
	,						
	Review of Res	sident #F's MDS					
	(Minimum Da	ta Set) Assessment,					
	dated 1/21/11,	indicated, she					
	needed extensi	ive physical					
	assistance of t	wo staff for toilet use					
	(how resident	uses the toilet room,					
	commode, bed	lpan, or urinal;					
	transfers on/of	f toilet; cleanses self					
	after elimination	on). It further					
	indicated Resi	dent #F was					
	frequently inco	ontinent of urine and					
	occasionally in	ncontinent of bowel.					
	ŕ	pdated 1/20/11,					
	ŕ	oblem(s): I require					
	extensive assis						
	,	aily living) due to					
		reased mobility and					
		Approach(s):					
	_	ne to use call light for					
		mind me where it is					
	-	eady to leave the					
	roomI need a	assist with proper					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	NSTRUCTION	(X3) DATE S COMPL	ETED
		155506	B. WIN			03/15/2	011
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
SANCTU	ARY AT HOLY CRO	DSSINDIANA			DUGDALE DR BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	DULD BE COMPLET	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	*	each incontinint (sic)					
	episode"						
	A Social Servi	ce Progress Note,					
	dated 1/24/11	at 3:42 P.M.,					
	indicated, "R	Res (resident) is alert					
	and oriented to	person with					
	forgetfulness	Severe cognitive					
	impairment'	"					
	During an inte	rview with a second					
	family membe	er on 3/15/11 at 4:20					
	-	cated it takes a long					
	•	o answer call lights.					
		licated she found her					
		(bowel movement)					
	three weeks ag						
		<i>)</i> - ·					
	A facility police	ev titled					
	"Incontinence	•					
		d 1/08/11, indicated,					
	•	functional (total)					
	_	frequently assess the					
		al and functional					
	_						
	statusrespon						
		an the perineal area					
		ntrol foul odors as					
	well"						

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION		(X3) DATE : COMPL	
		155506	A. BUI B. WIN	LDING IG			03/15/2	011
		<u> </u>	P. WIN		DDRESS, CITY, STATE,	ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	UGDALE DR			
SANCTU	ARY AT HOLY CRO	OSSINDIANA		1	BEND, IN46635			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN			(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	O THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIE	NCT)		DATE
TAG	A facility police Management, indicated, "If fecal incontine follows any loanal sphincter effective hygies the patient's conskin breakdow. Clean the period with a skin clean skin protectant.	cy titled, Incontinence Fecal," dated 1/08/11, In elderly patients, Ince commonly Is or impairment of Is controlmaintain Incenic care to increase Is omfort and prevent Is on and infection. Ineal area frequently Is aner, and apply a It cream after every Is pisode. Control foul		TAG		O THE APPROPRIAT	E	DATE
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	SQIC11	Facility II	D: 001201	If continuation sh	neet Pa	ge 24 of 48

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155506	A. BUII B. WIN			03/15/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L			DUGDALE DR		
	ARY AT HOLY CRO				I BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	, and the second se	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
F0241		record for Resident #	F02		What corrective action will	he	03/29/2011
			1.02	+1	accomplished for those reside		03/29/2011
SS=E		n 3/15/11 at 2:55			found to be affected by the		
		d diagnoses of, but			deficient practice: Head to toe skin assessments were		
	not limited to:	hypertension, CVA			completed on all resident to		
	(cerebrovascu	lar accident/stroke)			ensure skin integrity. Medline		
	with right hem	niparesis (weakness),			representatives and nursing administration reviewed		
	and expressive	e aphasia (loss of the			incontinence needs for		
	_	uce language).			incontinent residents and		
	definity to prod	uee miguage).			implemented new system and		
	During initial	tour of the facility			incontinence supplies to mana incontinent residents.2. How		
	conducted on 1	3/14/11 at 10:55			other residents having the		
	P.M., with LP	N # 5, Resident # C			potential to be affected by the same deficient practice will be		
		eep in her bed with			identified and what corrective		
		nately two feet by			action will be taken for any oth affected residents.Residents	ner	
	three feet, dry	, quilted, incontinent			requiring assistance with toilet	ing	
		th her bottom along			needs have the potential to be		
	_	ded in quarters,			affected.Medline representative and nursing administration	es es	
	•	three inches thick,			reviewed incontinence needs	for	
					incontinent residents and		
	_	tinent pad between			implemented new system and incontinence supplies to mana		
		ding from the small of			incontinent residents.Head to	-	
	_	her naval. LPN # 5			skin assessments were		
	removed the p	ad between the			completed on incontinent residents to assure skin		
	Resident's legs	S.			integrity.Nurse administration		
					been assigned on off hour shift to assure call lights and care of		
		ated she would find			residents is timely including		
	out who the C	NA was that placed			answering call lights,		
	the pad between her legs.				incontinence care and dignity provided.3. What measures w		
				be put into place or what syste			
	Review of the	"MDS (Minimum			changes will be made to ensu		

001201

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPLETED	
		155506	B. WIN			03/15/2011	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CANOTH		ACC INDIANA		1	DUGDALE DR		
	ARY AT HOLY CRO				H BEND, IN46635		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE	
	Data Set)Nu			0	that the deficient practice does		
	, ,				not recur. All staff was inservice	l l	
	· ·	essment", dated			on the expectation and		
		ed "Cognitive skills			responsibilities of answering c lights. Dignity training was	all	
	for daily decisi	ion			provided to all staff.4. How the	e	
	makingmode	erately			corrective action will be monitor		
	impaired-decis	sions poor;			to ensure the deficient practice will not recur. Nursing	•	
	cues/supervision	on requiredADL			administration will audit all uni	ts I	
	(activities of d	•			for compliance with answering		
	self-performan	• •			call lights and incontinence ca		
	•	e assistanceone			is provided timely, one time pe shift on all 3 shifts and a total		
					four times per week report	~·	
		ıl assistUrinary			findings to the Director of Nurs		
	continenceFr	requently			at morning clinical meeting.So		
	incontinent"	1			worker will randomly question staff per day 5 days a week to		
					ensure staffs inowledge of abu		
	A facility care	plan for Resident #			and neglect responsibilities an	d	
	C, dated 3/10/2	-			report findings to the administrator daily at clinical		
	·	I am incontinent of			meetings.Social Worker will		
	` ′				interview 5% of residents and		
		d bladderKeep me			families weekly to ensure qual	ity	
	dry and clean a				of care is being provided to residents.Corporate Regional		
	incontinence e	pisodeRespond to			Nurse will round community		
	my call light p	romptly"			daily 3 days per week for 6		
					months to ensure call lights ar		
	This federal ta	g relates to			answered and incontinence ca is provided timely.Director of	116	
	Complaints IN	~			Nursing and Administrator will		
		00007330.			review, follow up and report at	udit	
	2.1.2()				findings to (MDQI) monthly until 100% compliance is		
	3.1-3(t)				obtained times 3 months.5.		
					Completion date March 29, 20	)11	
FORM CMS-2	567(02-99) Previous Version	ns Obsolete Event ID: <b>S</b>	QIC11	Facility	ID: 001201 If continuation sl	heet Page 26 of 48	

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		155506	B. WING		03/15/2011	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t .	l l	DUGDALE DR		
SANCTU	ARY AT HOLY CRO	ANDIANA		H BEND, IN46635		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
					<b> </b>	
			1			
			1			
			1			
			1			
				1		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPL	ETED
		155506	B. WIN			03/15/2	011
NAME OF I	PROVIDER OR SUPPLIER		_	STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER			17475	DUGDALE DR		
	ARY AT HOLY CRO				H BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION DATE
F0309		rvation, interview,	F03		What corrective action will		03/29/2011
SS=D		iew, the facility			accomplished for those reside found to be affected by the	nts	
	failed to respo	nd to call lights and			deficient practice: Head to toe		
	_	a timely manner for			skin assessment were completed on all resident to		
	_	s in the sample of 5			ensure skin integrity. Medline		
		and #F) and 1 of 2			representatives and nursing		
	`	e supplemental			administration reviewed incontinence needs for		
		Resident #H) reviewed			incontinent residents and		
	for care and se	· ·			implemented new system and		
	101 care and se	i vices.			incontinence supplies to mana incontinent residents. 2. How		
	r. 1 1	1			other residents having the		
	Findings inclu	de:			potential to be affected by the		
					same deficient practice will be identified and what corrective		
	1. Resident # I	E's clinical record was			action will be taken for any oth	er	
	reviewed on 3	/15/11 at 3:00 P.M.			affected resident:Resident		
	and indicated	diagnoses of, but not			requiring assistance with toilet needs have the potential to be		
	limited to: lun	g cancer, DVT (deep			affected.Medline representativ		
	vein thrombos	is) and pulmonary			and nursing administration		
	emboli.	•			reviewed incontinence needs incontinent residents and	or	
					implemented new system and		
	During an inte	rview with alert and			incontinence supplies to mana incontinent residents. Head to	-	
	•	ent # E on 3/15/11 at			skin assessments were	io <del>c</del>	
		indicated she often			completed on incontinent		
		o or more hours			residents to assure skin integrity. Nursing administration	, l	
		ne comes to answer			has been assigned on off-hou		
					shifts to assure call lights and		
	_	'If a person died in			care of residents is timely.3.		
	this place, no one would know until morning. What if my roommate had a heart attack? How would I get her				What measures will be put into place or what systemic change		
					will be made to ensure that the		
					deficient practice does not		
					recur.All staff inserviced on the	₹	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING		COMPL	ETED
		155506	B. WIN			03/15/2	011
NAME OF L	DOLUBER OF GURRIUS	\		STREET A	ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF I	PROVIDER OR SUPPLIEF	C		17475 [	DUGDALE DR		
	IARY AT HOLY CRO				H BEND, IN46635		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION DATE
IAG		ther indicated she		IAG	expectation and responsibilitie		DAIL
	1 ^	n a laxative because			anwersing call lights timely,on		
		g difficulty with			time per shift on all 3 shifts an total of four times per week re		
					findings to the Director of Nurs		
	1 -	nd had soiled herself.			at morning clinical		
	"I had Depend	l's (an incontinence			meeting. Medline representative	ves	
	l	to keep a Depend's			and nursing administration provided education to direct ca		
	1	u never know when			staff related to providing care to	for	
	l • · · · ·	e going to show up.			incontinent residents and implementation for the system		
	(CNA # 2) car	ne in and told me she			and use of incontinent		
	would clean n	ne up when I finished.			supplies.4. How will the		
	I didn't know	if I was finished or			corrective action be monitored ensure the deficient practice w		
	not. I know it	was loaded. She			not recur.Nursing administration		
	made me wait	a long time before			will audit all units for complian with answering call lights	ce	
		to clean me up. The			and providing incontinence ca	re	
		outt was sore and			timely, randomly on all 3 shifts		
	1	(age) years old and			and report findings to the Direct of Nursing at morning clinical	ctor	
	1	my pants two times			meeting.Corporate Regional		
	·	ecause no one came."			Nurse will round community daily 3 days per week for 6		
		ndicated she had			months to ensure call lights ar	e l	
	l	Social Worker #8			answered and incontinence ca		
	1 -				is provided timely. Director of Nursing and Administrator will		
	about her cond	Cerns.			review, follow up and report at	udit	
	A Social Same	ica MDS (Minimum			findings to (MDQI) monthly		
		ice MDS (Minimum			until 100% compliance is obtained times 3 months.5.		
	l ′	essment Note, dated			Completion date March 29,20	11	
	3/15/11, indicated, "Resident (#E) is alert and oriented to time, place,						
	and situation. Resident scored 15						
	out of 15 indicating normal						
		<i>5</i>					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE S	ETED	
		155506	B. WIN			03/15/2	011
NAME OF F	ROVIDER OR SUPPLIER		•	1	ADDRESS, CITY, STATE, ZIP CODE		
SANCTU	ARY AT HOLY CRO	DSSINDIANA		1	DUGDALE DR I BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES	_	ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	RRECTIVE ACTION SHOULD BE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	cognitive func	tioning on					
	3/07/11"						
	Nurse's Notes,	dated 3/09/11 at 2					
	P.M., indicated	d, "tub bath given.					
	Skin check rev	vealed 2 areas of					
	excoriation bil	at (bilaterally) inner					
	buttocks L (lef	ft) inner buttocks					
	measures 0.5 x	x 1.0 (centimeters)					
	pink tissue & l	R (right) inner					
	buttocks meas	ures 1.0 x 1.5					
	(centimeters) p	oink tissue superficial					
	depth"	·					
	•						
	An "Admission	n Resident Data Set					
	Assessment,"	undated, indicated					
	she did not hav	ve the above					
	mentioned are	as upon admission on					
	3/04/11.	•					
	During observ	ation of Resident #					
	_	5/11 at 5:05 P.M.,					
	while accompa						
	_	Resident E's open					
	areas appeared	-					
		ndicated at the time					
		tion that the areas no					
	longer caused her pain.						
	ionger educed	nor pani.					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155506	A. BUII B. WIN			03/15/2	011
NAME OF F	PROVIDER OR SUPPLIER			_	ADDRESS, CITY, STATE, ZIP CODE	<u>I</u>	
				1	DUGDALE DR		
	ARY AT HOLY CRO			<u>L</u> .	BEND, IN46635		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	DATE
TAG	2. During inition 3/14/11 at 1 accompanied by #H was observed. Her call light of her bed. LF the blankets ar #H to determine incontinent. A was observed by sheet and on to groin area. The odor present. Verepositioned the dry, golden broobserved bene outer ring of the brown than the indicated the are reviewed on 3 and indicated to: dehill accompanies with the continuation of the conti	al tour of the facility 11:45 P.M., while by LPN # 7, Resident red lying in her bed. control was observed boor at the right side PN # 7 pulled back and checked Resident the if she had been white terry towel lying beneath the top op of Resident H's ere was a strong urine When LPN #7 the resident, a large, own area was ath Resident #H. The the area was a darker the center. LPN #7 threa was dry.  linical record was 15/11 at 6:10 P.M. diagnoses of, but not theydration, dyspnea oreath) on exertion,		TAG	DEFICIENCY)		DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M A. BUI		NSTRUCTION	(X3) DATE S COMPL	ETED
		155506	B. WIN			03/15/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	•	
SANCTU	ARY AT HOLY CRO	DSSINDIANA		1	DUGDALE DR I BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	DEND, INTOOOS	-	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IIE .	DATE
	10:30 P.M., in use call light eneedsExtens care-toileting, dressing, ADL living)"  During intervious the time of the indicated the esure all the resure all the resu	ive assist for personal personal hygiene, 's (activities of daily ew with LPN #7 at observation, she evening shift makes idents are clean and rior to leaving their P.M. and the night					

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155506				LDING	INSTRUCTION	(X3) DATE S COMPL 03/15/2	ETED
NAME OF I	PROVIDER OR SUPPLIEI	<b>"</b> ?	_	1	ADDRESS, CITY, STATE, ZIP CODE		
SANCTL	JARY AT HOLY CRO	DSSINDIANA			DUGDALE DR I BEND, IN46635		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	<b>†</b>	a contraction and immediately		TAG	DEFICIENC!)		DATE
		light had been turned					
		the time, the resident					
		out and Resident #F's					
		t into the room to					
	_	resident. She informed					
	the resident to	put her call light					
		vas told by the					
	resident that s	he had tried, but it					
	stopped worki	ing. "I know someone					
	did something	because I've found					
	my mother's c	all light like that. We					
	have waited to	wo hours with the call					
	light on during	g the evening shift.					
	There's nothing	g you can do about it					
	because there	isn't anyone around.					
		on't answer the lights,					
	1	medications and sit at					
		willing to organize a					
		the facility can afford					
	1	part-time help. I hear					
		out 'Help me. Help					
	me."						
	Resident #F's	clinical record was					
		/15/11 at 4:35 P.M.					
		diagnoses of, but not					
		tory of CVA (stroke),					
		• • • • • • • • • • • • • • • • • • • •					
	ļ						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155506		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED 03/15/2011		
		155506	B. WIN			03/15/2	011
	PROVIDER OR SUPPLIER			17475 C	DDRESS, CITY, STATE, ZIP CODE DUGDALE DR BEND, IN46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	diabetes, and v	vascular dementia.					
	(Minimum Da dated 1/21/11, needed extension assistance of the commode, bed transfers on/of after elimination indicated Resident frequently inconscasionally in the coccasionally in the coccasionally in the coccasional frequently inconscasionally in the coccasional frequently inconscasionally in the coccasional frequently inconscasionally in the coccasional frequently inconscasional frequently inconscasiona	ive physical wo staff for toilet use uses the toilet room, Ipan, or urinal; If toilet; cleanses self on). It further dent #F was ontinent of urine and acontinent of bowel.  Input details of the second of the seco					
		·					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155506		A. BUII	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED 03/15/2011	
	PROVIDER OR SUPPLIER		B. WING O3/13/2011  STREET ADDRESS, CITY, STATE, ZIP CODE  17475 DUGDALE DR  SOUTH BEND, IN46635				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	and oriented to forgetfulness impairment'  During an inte family member P.M., she indicating for staff to the further income.	rview with a second or on 3/15/11 at 4:20 cated it takes a long o answer call lights.					
	She further indicated she found her mother in BM (bowel movement) three weeks ago.  A facility policy titled "Incontinence Management, Urinary," dated 1/08/11, indicated, "To manage functional (total) incontinence, frequently assess the patient's mental and functional statusrespond to his calls promptly"  A facility policy titled, Incontinence Management, Fecal," dated 1/08/11, indicated, "In elderly patients,						
	follows any lo	ence commonly ss or impairment of controlmaintain					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155506			LDING	NSTRUCTION	(X3) DATE : COMPL 03/15/2	ETED	
	PROVIDER OR SUPPLIER		1	17475 D	DUGDALE DR BEND, IN46635	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	the patient's co	enic care to increase omfort and prevent on and infection"					
	This federal ta						
	3.1-37(a)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155506	B. WIN			03/15/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			17475	DUGDALE DR		
	ARY AT HOLY CRC				H BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		E	COMPLETION DATE	
F0312		LSC IDENTIFYING INFORMATION)	F03		What corrective action will I	20	
SS=E		rvation, interview,	F03	12	accomplished for those reside		03/29/2011
33-E		iew, the facility			found to be affected by the deficient practice:Head to toe		
	-	de continence care in			assessment were completed of	n	
		er for 4 incontinent			all resident to ensure skin	voc	
		deficient practice residents (Residents:			integrity. Medline representati and nursing administration	v <del>c</del> 5	
					reviewed incontinence needs f	or	
	*	the sample of 5 and 2 (Residents #G and			incontinent residents and implemented new system and		
		`			incontenance supplies to man	age	
		plemental sample of			incontinent residents.2. How		
	2 reviewed for	continence care.			other residents having the potential to be affected by the		
					same deficient practice will be		
	Findings inclu	de:			identified and what corrective		
	Č				action will be taken for any oth	er	
	1 During init	ial tour of the facility			affected resident.Residents requiring assistance with toilet	ina	
	•	11:10 P.M., while			needs have the potential to be		
					affected.Medline representativ	es	
	•	by LPN # 5, Resident			and nursing administration reviewed incontinence needs f	or	
		ved lying asleep in his			incontinent residents and	-	
		identified Resident			implemented new system and		
		ent and in need of			incontenance supplies to mana incontinent residents.Head to	•	
		ks for incontinence.			assessments were completed		
	Upon further of	bservation, Resident			incontinent residents to assure		
	#G was found	to be soiled from			skin integrity.Nurse administra has been assigned on all off-h		
	urine. His aui	lted incontinence pad			shifts to assure call lights and	Jui	
		et area surrounded by			care of residents is timely.3.		
		·			What measures will be put into		
		solden brown stain of			place or what systemic change will be made to ensure that the		
	dried urine.				deficient practice does not	<b>,</b>	
	_				recur.All staff inserviced on the		
	Review of Res	Review of Resident #G's clinical			expectation and responsibilitie answering call lights	s of	
					answering can lights		
					ļ		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY  COMPLETED	
AND FLAN	OF CORRECTION	155506	1	LDING		03/15/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				DUGDALE DR		
	ARY AT HOLY CRO				BEND, IN46635		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COM	(X5)
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	E.	PLETION DATE
		7/11 at 5:35 P.M.,			timely.Medline representatives		
	indicated diag	noses of, but not			and nursing administration provided education to direct ca	are	
	limited to: Ala	zheimer's dementia,			staff related to providing care	I .	
	depression, and	d history of urinary			incontinent residents and implementation for the system		
	tract infection.				and use of incontinent		
					supplies.4. How will the corrective action be monitored	4-	
	Resident #G's	most recent quarterly			ensure the deficient practice w	••	
	MDS (Minimu	ım Data Set)			not recure. Nursing administration		
	assessment, da	ated 2/11/11,			will audit all units for complian with answering call lights and	Je	
	indicated his c	ognition was	providing incontinence care				
	severely impaired and he never or			timely, one time per shift on all shifts and total of four times pe			
	rarely made de	ecisions. It further			week report findings to the		
	indicated he no	eeded extensive			Director of Nursing at morning clinical meetings.Coroporate		
	assistance of ty	wo persons with			Regional Nurse will round		
	physical assist	-			community daily 3 days per w		
	1 3	C			for 6 months to ensure call light are answered and incontinent	l l	
	A Care Plan, d	lated 1/11/11.			care is provided timely.Directo	l l	
	· ·	blem: I have altered			Nursing and Administrator will review, follow up and report at	ıdit	
	ŕ	ation pattern related			findings to (MDQI) monthly	idit	
	to dx. (diagnos	-			until 100% compliance is		
	` `	proach:Keep me			obtained times 3 months.5. Completion date March 29, 20	11	
	dry and clean a	•			23.115.00.01.00.01.01.20, 20		
	-						
	incontinence e	pisouc					
	A Nursa's Note	e, dated 3/15/11 at					
		dicated, "Resident					
	· ·						
	continues on a						
	(diagnosis) UT	I (urinary tract					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155506  A. BUILDING  B. WING		NSTRUCTION	(X3) DATE SURVEY  COMPLETED  03/15/2011			
	PROVIDER OR SUPPLIER		17475 [	DUGDALE DR BEND, IN46635	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE	(X5) COMPLETION DATE
	infection)res	bowel & bladder"				
	on 3/14/11 at accompanied to accompanied to accompanied to the H was observed between the blankets are to do to the blankets are to do the blankets	ne resident, a large, own area was ath Resident #H. The he area was a darker e center. LPN #7				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155506		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  D. WING			(X3) DATE SURVEY COMPLETED 03/15/2011		
	PROVIDER OR SUPPLIER		B. WING	STREET A	DUGDALE DR BEND, IN46635	<u> </u>	
	ARY AT HOLY CRC  SUMMARY S (EACH DEFICIEN REGULATORY OR  (shortness of b and failure to t  A Nurse's Note 10:30 P.M., in use call light e needsExtens care-toileting, dressing, ADL living)"  During intervi the time of the indicated the e sure all the res repositioned p shift at 11:15 I shift begins re- immediately a  3. Resident # was reviewed P.M. and indice	personal hygiene, l's (activities of daily  we with LPN #7 at observation, she evening shift makes idents are clean and rior to leaving their  P.M. and the night	B. WING	STREET A	DUGDALE DR		(X5) COMPLETION DATE
	DVT (deep ve pulmonary em	in thrombosis) and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY  COMPLETED	
		155506	A. BUI B. WIN			03/15/2011	
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE	!	
				1	DUGDALE DR		
	ARY AT HOLY CRO	TATEMENT OF DEFICIENCIES			BEND, IN46635		(V5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ME.	DATE
	oriented Resid	lent # E on 3/15/11 at					
	2:40 P.M., she	indicated she often					
	has to wait two	o or more hours					
		ne comes to answer					
	_	'If a person died in					
	•	one would know until					
	_	t if my roommate had					
		How would I get her					
	•	ther indicated she					
	•	n a laxative because					
	`	g difficulty with					
	_	nd had soiled herself.					
	"I had Depend	s (an incontinence					
	brief) on. I try	to keep a Depend's					
		u never know when					
		e going to show up.					
	,	ne in and told me she					
		ne up when I finished.					
	I didn't know i	if I was finished or					
		was loaded. She					
		a long time before					
		to clean me up. The					
	next day my b	utt was sore and					
	bleeding. I am	(age) years old and					
	_	my pants two times					
	in one night be	ecause no one came."					
	A Social Servi	ce MDS (Minimum					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPLETED	
		155506	B. WIN			03/15/2011	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SANCTU	IARY AT HOLY CRO	SSINDIANA		1	DUGDALE DR I BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	1 52(15), 11 10000	(X	5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLI	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DAT	Е
	Data Set) Asse	essment Note, dated					
	3/15/11, indicated, "Resident (#E)						
	is alert and ori	ented to time, place,					
	and situation.	Resident scored 15					
	out of 15 indic	eating normal					
	cognitive func	-					
	3/07/11"	S					
	4. During initi	al tour of the facility					
	on 3/14/11 at 11:50 P.M., Resident						
		ember reported the					
		of facility staff to					
	1 ^	lights and providing					
	_	e. She indicated she					
	1	mother with dried					
		ackside and between					
	_	quently find her with					
		er call light disabled					
	_	organize a fund raiser					
	1	can afford to hire					
	_	e help. I hear people					
	calling out 'He	elp me. Help me'."					
	<b>5</b> 11 11 11 11 11 11 11 11 11 11 11 11 11	4 4					
		clinical record was					
		/15/11 at 4:35 P.M.					
		diagnoses of, but not					
	limited to: hist	tory of CVA (stroke),					
	diabetes, and v	vascular dementia.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155506			A. BUI	LDING	NSTRUCTION	(X3) DATE S COMPL 03/15/2	ETED
		10000	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/10/2	
NAME OF F	PROVIDER OR SUPPLIER			1	DUGDALE DR		
	ARY AT HOLY CRO			SOUTH	BEND, IN46635		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
		sident #F's MDS					
	`	ta Set) Assessment,					
	dated 1/21/11,						
	needed extensi	• •					
		wo staff for toilet use					
	`	uses the toilet room,					
	· ·	lpan, or urinal;					
	transfers on/off toilet; cleanses self						
	after elimination). It further						
	indicated Resi						
		ontinent of urine and					
	occasionally in	ncontinent of bowel.					
	A Care Plan. u	pdated 1/20/11,					
	•	blem(s): I require					
	extensive assis	• •					
	(activities of d	aily living) due to					
	`	reased mobility and					
	· ·	Approach(s):					
		ne to use call light for					
	_	mind me where it is					
		eady to leave the					
	-	assist with proper					
		each incontinint (sic)					
	episode"						
	- cp150 <b>dc</b>						
	A Social Servi	ce Progress Note,					

A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 17475 DUGDALE DR	15/2011
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE	
17475 DIIGDAI F DR	
SANCTUARY AT HOLY CROSSINDIANA SOUTH BEND, IN46635	(77.5)
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
dated 1/24/11 at 3:42 P.M.,	
indicated, "Res (resident) is alert	
and oriented to person with	
forgetfulnessSevere cognitive	
impairment"	
During an interview with a second	
family member on 3/15/11 at 4:20	
P.M., she indicated it takes a long	
time for staff to answer call lights.	
She further indicated she found her	
mother in BM (bowel movement)	
three weeks ago.	
A facility policy titled	
"Incontinence Management,	
Urinary," dated 1/08/11, indicated,	
"To manage functional (total)	
incontinence, frequently assess the	
patient's mental and functional	
statusrespond to his calls	
promptlyclean the perineal area	
frequentlycontrol foul odors as	
well"	
A facility policy titled, Incontinence	
Management, Fecal," dated 1/08/11,	
indicated, "In elderly patients,	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	IDENTIFICATION NUMBER:  155506	(X2) MULTIPLE CO  A. BUILDING  B. WING	INSTRUCTION	COMPI 03/15/2	LETED
	PROVIDER OR SUPPLIER		STREET A 17475 [	ADDRESS, CITY, STATE, ZIP COD DUGDALE DR 1 BEND, IN46635	E	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	follows any lo anal sphincter effective hygie the patient's co skin breakdow Clean the perio with a skin cle skin protectan	g relates to				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPLETED	
		155506	B. WING			03/15/2	011
			l		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			17475	DUGDALE DR		
	ARY AT HOLY CRO				H BEND, IN46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	E0.4	TAG	F 4691. What corrective actio	<u> </u>	DATE
F0469		rvation, interview,	F04	69	will be accomplished for those		03/29/2011
SS=E		iew, the facility de adequate pest			residents found to be affected the deficient practice:Pest con		
	_				was notified on 3/15/11 for follo		
		lenced by live ants			up service. On 3/16/11 Pest		
	_	the East Dining			control was here found no ants East Dining Room. They did	s in	
		eficient practice had			apply ant bait to dining room.2		
	_	affect 58 of 58			How other residents having the	е	
	residents resid	ing on the East Unit.			potential to be affected by the same deficient practice will be		
				identified and what corrective			
	Findings include:				action will be taken for any oth		
					affected resident.Residents in East Dining room have the	the	
	During environ	nmental tour of the			potential to be affected. The		
	_	oom on 3/15/11 at			facility has a monthly Pest Cor		
	_	to 12 small red ants			provider and they will come as needed when pest are identified		
	· ·	along the cove base			in facility.3. What measures w		
					be put into place or what syste		
	directly under				changes will be made to ensure that the deficient practice does		
		ant amount of brown			not recur.Maintenace Director		
	particles were	on the floor by the			designee will do rounds Mond		
	cluster of ants.	A large web was			thru Friday to check for insects		
	also observed	in the corner along			pest in facility. All staff will rep to Maintenace Director or	π	
	the floor base	on the East wall and			Administrator if they notice any		
	contained a liv	ve spider			pest in building. Maintenace w	ill	
		L			remove pest and pest control company will be notified	-d	
	During on into	rview with a family			of issue.4. How the corrective		
	_	rview with a family			action will be monitored to ens	ure	
		sident # E on 3/14/11			the deficient practice will not		
	<i>'</i>	she indicated on			recur, what quality assurance program will be put in place.The	ne	
	3/11/11 she ob	served numerous,			Maintenenace Director will rep		
	small black an	ts in the Resident's			results of rounds to the Missio	n	
					Driven Quality Improvement		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		NSTRUCTION	(X3) DATE SURVEY COMPLETED 03/15/2011		
	PROVIDER OR SUPPLIER		B. WINC	STREET A	DUGDALE DR BEND, IN46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē.	(X5) COMPLETION DATE
	of her floor ve used a medicir ants and then he attention of the On 3/15/11 at interview with indicated she froom that more her self out into the Maintenan care of the anti-care of the anti-care of the anti-care of the indicated, "The when the room. I usu border of the room. I scrappray the floof for awhile."  The Main indicated in a series of	nterview with Employee 5/11 at 3:10 P.M., he only time I see ants is resident's eat in their ally see them along the nee floor in the dining ape them up and then I for and it usually lasts tenance Supervisor an interview on 3/15/11, he went into Resident			(MDQI) monthly times 3 month. The MDQI committee will reviet findings to determine if audits be suspended, if consistent compliance is met for one quarter. Additional Action Plan will be created and implement as needed based on findings audits.5. Completion date Ma 29,2011	ew can ns ed of	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155506			(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	(X3) DATE COMPI 03/15/2	LETED
	PROVIDER OR SUPPLIEF		17475 [	ADDRESS, CITY, STATE, ZIP CODE DUGDALE DR I BEND, IN46635	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	Е	(X5) COMPLETION DATE
	Review of received on from the lindicated that Company se on 3/7/11 at "all community break rooms."	ng relates to				